STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner
v **File No. 84746-001-SF**

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 14th day of November 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 28, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it for external review on September 5, 2007.

Section 2(2) of Act 495, MCL 550.1952(2), requires the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner initially thought the case could be decided by reviewing the contract. Later it was determined that medical issues were involved. Therefore, the Commissioner assigned the case to an independent review organization (IRO). The IRO provided its analysis and recommendation to the Commissioner on October 9, 2007.

The Petitioner is enrolled for health coverage through the State of Michigan's PPO health plan (the plan), a self-funded group that provides health care benefits to State of Michigan employees and their families. The plan is administered by Blue Cross and Blue Shield of Michigan (BCBSM). BCBSM's *Your Benefits Guide* (the benefits guide) sets forth the Petitioner's coverage, including restrictions and limitations.

II
FACTUAL BACKGROUND

The Petitioner says she has been using a continuous positive airway pressure (CPAP) device since 1999 and wants her old device replaced because she can no longer obtain a replacement mask that fits the unit. The Petitioner purchased a new CPAP device on May 15, 2007, for $1,300.00. BCBSM denied coverage for this item.

The Petitioner appealed BCBSM's denial of coverage. BCBSM held a managerial-level conference on July 6, 2007, and issued a final adverse determination dated July 18, 2007.

III
ISSUE

Is BCBSM required to cover the Petitioner's CPAP device purchased on May 15, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's pulmonologist indicated that she was diagnosed with sleep apnea in XXXXX, Indiana, in 1999 and has been using a CPAP device at 8 cm pressure. The pulmonologist said that she does not have severe obstructive sleep apnea.

The Petitioner was advised by her physician to have a sleep study before she purchased a new CPAP device because BCBSM would not approve it without a valid study. An attempted polysomnogram on March 13, 2007, was terminated because the Petitioner could not maintain sleep for the 120 minutes needed to evaluate her condition. On May 3, 2007, the Petitioner had a

second

sleep study where she was titrated and allowed to use her CPAP device; she was able to sleep the required 120 minutes.

The Petitioner does not think it is fair for BCBSM to deny her a new CPAP machine just because she was unable to complete the portion of the test that required her to sleep without the device. She has used this device successfully for nine years and feels that it is dangerous for her to sleep without using it. She says that just because she was unable to sleep for two hours without the CPAP device does not mean her sleep apnea is cured.

The Petitioner argues that a CPAP machine is medically necessary for her and a benefit under her coverage. Therefore, she believes that BCBSM is required to cover a new CPAP device.

BCBSM's Argument

BCBSM acknowledges that durable medical equipment (DME) is a covered benefit when it meets medical necessity criteria. BCBSM uses the standards established by Medicare to determine eligibility for a CPAP device. Medicare's medical policy provides that a CPAP device will not be approved unless the Petitioner has an apnea-hypopnea index (AHI) of a certain value documented by an attended polysomnograph that is based on a minimum of two hours (120 minutes) of sleep without the use of a CPAP device.

BCBSM submitted the Petitioner's medical records to the medical director of DMEnsion Benefit Management, which processes DME claims for the plan. After reviewing the records, DMEnsion denied coverage because an appropriate sleep study was not obtained.

BCBSM believes it acted correctly in denying the Petitioner's CPAP device since she had not met its required criteria for medical necessity.

Commissioner's Review

The issue to be resolved in this case is whether the Petitioner met the medical necessity criteria for a CPAP device. This issue was presented to an IRO for analysis as required by Section

11(6) of PRIRA, MCL 550.1911(6). The IRO reviewer is a physician in active practice for more than 20 years who is board certified in internal medicine and pulmonary medicine.

The IRO reviewer explained that according to nationally accepted criteria, such as Medicare's, a polysomnogram must result in an AHI of 15 or greater unless there are documented symptoms of hypertension, heart disease, or a cerebrovascular accident, and there was no documentation. The IRO reviewer noted that the Petitioner's AHI from any sleep study in 1999 was not provided for review. Furthermore, the Petitioner's sleep study in March 2007 resulted in only 20 minutes of recorded sleep time instead of 120. The IRO reviewer also said there is no documentation in this case that demonstrates that the Petitioner has a diagnosis of moderate to severe obstructive sleep apnea.

The IRO physician consultant concluded that a CPAP device is not medically necessary for treatment of the Petitioner's condition because she has not met the nationally accepted criteria.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the recommendation is afforded great deference by the Commissioner because it is based on extensive expertise and professional judgment. The Commissioner can discern no reason why the IRO recommendation should be rejected in the present case. Therefore, the Commissioner accepts the conclusion of the IRO and finds that a CPAP machine is not medically necessary for the Petitioner's condition.

V
ORDER

Respondent BCBSM's final adverse determination of July 18, 2007, is upheld. BCBSM is not required to cover the Petitioner's CPAP device since the medically necessity has not been shown.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham

County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of

Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.